Mental Welfare Commission for Scotland

Report on announced visit to:
The Royal Edinburgh Hospital, The William Fraser Centre, Morningside Road, Edinburgh, EH10 5HF

Date of visit: 13 May 2025

Our local visits detail our findings from the day we visited; they are not inspections. Although there are specific things we ask about and look for when we visit, our main source of information on the day of a visit is from the people who use the service, their families/carers, the staff team, our review of the care records and our impressions about the physical environment. We measure this against what we would expect to see and hear based on the expectations of the law, professional practice and known good practice e.g. the Commission's good practice guides.

Where we visited

The William Fraser Centre is part of NHS Lothian's learning disability service, located in the grounds of the Royal Edinburgh Hospital. The William Fraser Centre has 12 beds and is divided into three areas, Strathaird, Culzean and Rannochmor. The centre is the main admission service for people with learning disabilities across NHS Lothian. It admits individuals with a mild to moderate learning disability, who may have additional difficulties, such as mental ill health, forensic needs, autism, and/or challenging behaviour.

On the day of our visit, there were 12 individuals in the William Fraser Centre; four of those individuals were considered to have the discharge from the service delayed. A delayed discharge occurs when an individual who is clinically ready for discharge continues to occupy a bed, usually because of delays in securing a placement in a more appropriate setting. We heard that these individuals were actively involved in discharge planning. We were pleased to hear that since our last visit in March 2024, four individuals had been discharged into the community and that some individuals had imminent discharge dates.

Our last visit in 2024 was announced and we made recommendations in relation to the environment, specifically for the service to address the outstanding environmental issues in relation to repairs, to update fixtures, fittings, decoration, and maintenance issues to make the environment more homely and therapeutic. The response we received from the service stated that all repairs would be reported to the estates department and there would be ongoing liaison with estates and maintenance services in the Royal Edinburgh Hospital to ensure that work required is completed in a timely manner.

On the day of this visit, we wanted to follow up on the previous recommendations, meet individuals, relatives/carers and staff to hear their views and experiences on how care and treatment was being provided on the ward

Who we met with

We met with six people in person and reviewed their care notes. We also spoke with four relatives.

We spoke with the clinical nurse manager (CNM), the senior charge nurse (SCN), charge nurse (CN), other members of nursing staff and one of the consultant psychiatrists. In addition, we contacted advocacy services.

Commission visitors

Kathleen Liddell, social work officer
Lesley Paterson, senior manager (practitioners)
Catriona Neil, ST6 learning disability psychiatrist

What people told us and what we found

The individuals we met with on the day of the visit were mainly positive about their care, support and treatment in the William Fraser Centre. The feedback included comments such as “staff are brilliant, they help me, are nice to me and take me out”, “staff give me lots of support” and “the staff I work with know me well, I trust them and I feel safe”.

Some individuals told us that they found it difficult when staff used humour during communication. We heard from these individuals that they did not find the use of humour supportive and interpreted this as “disrespectful” and “making fun of me”. We raised this matter with the CN and CNM on the day of the visit. We heard that some individuals had reported negative interactions they had had with staff to the SCN, and the matter was being investigated.

All individuals told us they had a key nurse that they met with regularly and found these interactions positive. Those that we spoke with were aware of their care plan and told us they had participated in the completion of it. We also heard from individuals that they met regularly with their consultant psychiatrist and all members of the multidisciplinary team (MDT) and mainly, they felt listened to and involved in decisions regarding their care, treatment and support. One individual told us that they did not always agree with the decisions made by the MDT however, their consultant psychiatrist took time to meet with them, to explain why these decisions had been made, which helped them better understand.

Many of the individuals we met with told us they felt frustrated at the amount of time they had been in hospital. Some individuals did not feel as though they needed to be in hospital and wanted to be discharged back into community living.

We heard from a number of people that they had a discharge care plan and that the discharge co-ordinator offered high levels of support and met with individuals regularly to discuss their discharge plans, any barriers to discharge and their views in relation to this. These individuals told us that they accessed advocacy services and that they had provided their views to the multidisciplinary team and for their Care Programme Approach (CPA) meetings.

All individuals were subject to CPA, which is a framework with a particular focus on planning the provision of care and treatment through the involvement of a range of different people and by keeping the individual and their recovery at the centre. We found the CPA paperwork to be of a high standard and regularly reviewed.

Most individuals raised concerns about the environment. We heard that bedrooms had damp patches, and one individual told us they had to move room due to an ant infestation. We also heard that the environment could be noisy, which caused some individuals to feel increased levels of anxiety. We discussed these issues with the

CNM who advised that any repairs that were required were immediately reported to the Royal Edinburgh Hospital (REH) estates department however, the response was not always timely.

Some people told us that the choice and quality of food had deteriorated. We heard that some meals were served cold and that not all individuals were provided with their choice of meal. We raised this with the CN and CNM on the day of the visit; we were told that the menus had recently changed and that feedback from the individuals had been sent to the catering department.

The relatives/carers we spoke to provided mainly positive feedback about the care and treatment in the William Fraser Centre. Most of the relatives/carers told us that the care their loved one received was good, with comments such as “the care is excellent”, “staff make efforts to get to know patients and the care is personalised” and “the staff are able to comfort my daughter when she is distressed and this gives me comfort”. We heard that staff were mainly caring, supportive and friendly and that relatives/carers felt welcomed when visiting.

We heard concerns from one relative over the care their loved one was receiving. We were told by the relative that they did not feel it was appropriate for staff to be using humour and ‘making fun’ of their loved one, especially given their diagnosis. The relative/carer reported this made them question some of the staff’s ability, knowledge and skills working with people with a learning disability and autism. We raised these concerns with the CNM on the day of the visit and were advised that the service was aware of these concerns raised and were in communication with the relative regarding these issues.

We heard from most relatives that they felt fully involved in decision-making and that their views were listened to and taken on board. Many relatives/carers told us about regular ‘family meetings’ they attended and that they found these supportive, as all members of the MDT and social work attended and their loved ones’ care and future planning was discussed.

Some relatives/carers raised concerns over the environment. One relative was very upset about an infestation of ants in their loved ones’ bedroom. We also heard concerns over the condition of the building with reports of issues such as damp, as well as repairs and decoration required. Relatives/carers told us that they felt a new building was required and that the current building “was not fit for purpose”.

Care, treatment, support, and participation

Care plans

We were advised and noted that NHS Lothian has implemented a new person-centred care plan in April 2025. At the time of this visit, most of the individuals’ care plans were stored in paper files. We were able to review two care plans that had

been transferred onto the new template on TRAKCare. We were told that there was a plan in place to transfer all the information in the paper files to the new person-centred care plans located on TRAKCare.

For individuals who's care plan has not been transferred, we reviewed their care records which were in paper files. We saw that the information recorded in the care and treatment plans supported admission goals, outcomes and identified plans of nursing care.

From reviewing these plans, we saw that people had a wide range of complex mental and physical health needs. We saw individuals had multiple plans to support all aspects of their care and treatment in the hospital and in the community. The information in these plans comprehensively detailed the care, treatment and support the individual required, providing a clear understanding for staff as to what nursing intervention was necessary to provide the support. The care plans were person-centred, evidenced a strengths-based approach with a focus on recovery to support discharge; they promoted the individuals' participation and where appropriate, relatives/carers input. This level of detail was fundamental in providing consistency and continuity of care for the individuals in the William Fraser Centre.

In reviewing two of the new person-centred care plans that were available on TRAKCare, we noted that these care plans had various headings that included mental health, stress and distress, activities of daily living, legislation, physical health, risk and activity. Although the care plans recorded the same quality of detail on the individuals' care, support and treatment needs, the information was more concise, with current and essential information easy to identify.

The care plans reviewed were person-centred and evidenced participation of the individual and their relatives where appropriate. We were pleased to see that the individuals who had one of the new care plans had been provided with a copy that contained easy read language, pictorial information and reflected the views of the individual.

We were unable to find consistent or regular views of the care and treatment plans taking place. We found that some of the care plans recorded in the paper files had not been reviewed since the last Commission visit.

We asked the CN and CMN how often reviews were completed in the William Fraser Centre and were told that they were completed on a six-monthly basis. We were told that some reviews were delayed due to the new care plans being implemented and a decision had been made that a comprehensive review would take place when all of the information had been transferred onto the new care plan. We advised that reviewing all care and treatment plans was required to regularly assess if the targeted intervention remained relevant.

The reviews that had been completed were comprehensive, providing a summative evaluation of the individual's progress. Many of the reviews included input from all members of the MDT. We saw care and treatment plans being adjusted following reviews, to support any areas of progress or elements of increased support needed.

The risk assessments we reviewed were of a high standard. Some individuals had various risks assessments that supported them in the ward and in the community. The level of detail in the risk assessments was robust and included identified risks, a detailed risk management plan and a safety plan. This level of detail provided all staff working with the individual to have a good awareness of the support they needed to ensure the individuals', and others, safety.

Physical health care in the William Fraser Centre was provided by the junior doctors and the nursing team. We heard that many of the nursing staff were trained in various physical health care treatments including venepuncture and undertaking electrocardiogram (ECG) testing. This supported consistency of care for individuals who could find it difficult to engage with unfamiliar medical staff. We were pleased to see that individuals were involved in national annual health screening programmes. We heard from the CNM that learning disability services in NHS Lothian were in the process of funding GP sessions to support physical health care.

Care records

Information on individuals care and treatment was held electronically on TRAKCare, which we found easy to navigate. Care records were recorded on a pre-populated template with headings relevant to care and treatment.

The care records we reviewed were of good quality and detailed what activities the individual had engaged in that day and what had been positive or challenging for them. The recorded information focused on the strengths of the individuals, encouraged skill development and independence.

Information recorded in the care records aligned with the treatment plans. We were pleased to see comprehensive recording from all members of the MDT that promoted a holistic and recovery-based approach to the care of individuals. There was evidence of frequent one-to-one interactions between individuals, nursing staff and their consultant psychiatrists. The individuals we met with told us they met with their key nurse and other members of the MDT regularly.

We found good examples of proactive discharge planning that evidenced the involvement of the individuals, welfare guardians and where appropriate, relatives. We heard and saw that the discharge co-ordinator was actively involved with individuals where discharge planning was in progress and saw weekly meetings with individuals to discuss discharge planning, which were reported as very positive.

We were pleased to hear that there were regular Health and Social Care Partnership (HSCP) meetings to discuss and support discharge planning as well as attendance at the dynamic support register group to identify and support individuals who were at risk of unnecessary hospital admissions.

We were pleased to find that the care notes included regular communication with families and relevant professionals. Many of the individuals in the William Fraser Centre had involvement with third sector providers. The communication with the providers was documented in care records

Multidisciplinary team (MDT)
The MDT consisted of two consultant psychiatrists, a junior doctor, nursing staff, recreational assistant, speech and language therapy (SALT), OT, art psychotherapist, music therapist and a discharge coordinator. All of the individuals had an allocated mental health officer (MHO) and most had a social worker.

Each consultant psychiatrist held a weekly MDT meeting. Individuals did not attend this meeting and instead, met with their key nurse before the meeting and discussed any issues or questions they wanted raised in the meeting.

When reviewing the MDT meeting records, we saw that individual's views and any care requests had been discussed and details on how these would be supported had been recorded. We heard and saw that the consultant psychiatrist met with the individual following the meeting to discuss the outcome. We heard from those that we spoke with that they felt involved in decisions regarding their care, support and treatment.

The weekly MDT meeting was recorded on a structured template. We found detailed recordings of the MDT discussions, decisions and personalised care planning for individuals. We were pleased to see clear links between MDT discussions and the treatment plan outcomes, as well as evidence that individuals were making progress and moving towards achieving the aims and goals of the admission. It was clear that the MDT was fully involved in each individual's care and committed to adopting a holistic and strengths-based approach to care and treatment.

Use of mental health and incapacity legislation

On the day of the visit, 10 people were detained under the Mental Health (Care and Treatment) (Scotland) Act, 2003 (the Mental Health Act). There was also use of s57 of the Criminal Procedure (Scotland) Act 1995 and a number of individuals subject to Adults with Incapacity (Scotland) Act, 2000 (the AWI Act).

All documentation in relation to the Mental Health Act was stored on TRAKCare and was easy to locate.

There had been a change in storing of documentation relating to the AWI Act; we were unable to locate welfare guardianship documentation on TRAKCare or in paper files. We were concerned that some of the staff we spoke with during the visit were unaware that some of the individuals in the William Fraser Centre were subject to welfare guardianship and had no knowledge of the welfare powers granted, or any powers that had been delegated. We were assured that the individuals we met with who were subject to welfare guardianship under the AWI Act, had a good understanding of what this meant for them.

Recommendation 1:
Managers should put a system in place to ensure awareness of when a welfare proxy is in place for an individual, and a copy of the document stating the powers of the proxy should be held within the case records.

The Commission will send a copy of this report to the Chief Social Work Officers of all four Lothian HSCP's to highlight the importance of delegated officers communicating with staff involved in any individual who is subject to a welfare guardianship order in the William Fraser Centre to ensure that they are aware of the order, the powers granted and any duties in relation to any delegated powers.

Part 16 of the Mental Health Act sets out the conditions under which treatment may be given to those individuals who are detained, who are either capable or incapable of consenting to specific treatments.

On cross-checking the electronic records for all that were in the William Fraser Centre at the time of our visit, there were eight individuals who had either a consent to treatment certificates (T2) or certificate authorising treatment (T3) under the Mental Health Act in place. However, we found that for six individuals who had medication prescribed, this was not authorised by the T2 or T3 certificate that was in place. We highlighted this issue on the day of the visit and were assured by the consultant psychiatrist and CNM that an urgent review of the T2 and T3 certificates would be undertaken, and individuals would be made aware of having had unauthorised treatment and their rights in relation to this.

Recommendation 2:
Managers and the responsible medical officers must ensure that all consent and authority to treat certificates are valid, that all psychotropic medication is legally authorised and that an audit system is put in place to monitor this.

Anybody who receives treatment under the Mental Health Act can choose someone to help protect their interests; that person is called a named person. Where a named person had been nominated, we found this documentation recorded on TRAKCare.

We saw that for individuals who had been identified as an adult at risk of harm under the Adult Support and Protection (Scotland) Act, 2007, the MDT were fully involved in risk assessment and the completion of the individual's protection plan.

Where an individual lacks capacity in relation to decisions about medical treatment, a certificate completed under section 47 of the AWI Act must be completed by a doctor. The certificate is required by law and provides evidence that treatment complies with the principles of the Act. The doctor must also consult with any appointed legal proxy decision maker and record this on the form. We found several incidences where an individual had a section 47 certificate in place, but the accompanying care plan did not always record essential information, such as the date issued and details of people consulted.

Recommendation 3:
Where a person lacks capacity in relation to decisions about medical treatment, s47 certificates and where necessary, treatment plans must be completed in accordance with the AWI Act Code of Practice (3rd ed.) and cover all relevant medical treatment the individual is receiving.

We discussed the changes in the recording and management of the legal documentation in the William Fraser Centre from the previous Commission visit and asked what audit processes were in place. We heard that previously, the member of medical staff who completed the audits of the legal documentation had moved on and that alternative arrangements needed to be prioritised. We highlighted that there were information boards recording legal information located in the nursing and doctor's offices and on review of these, they had incorrect and inconsistent information recorded on them. We discussed that it was essential that all information boards had current and accurate information recorded.

Rights and restrictions

The William Fraser Centre continued to operate a locked door, commensurate with the level of risk identified with the individual group. Information on the locked door policy was available at the main entrance to the centre.

The individuals we met with during our visit had a good understanding of their rights. Most were aware of their right to advocacy, and we saw from care records that many individuals had met with advocacy. We were pleased to note that most of those whose records we reviewed had legal representation. For those individuals unable to arrange legal representation, a curator ad litem had been requested to safeguard the interests of the individual in proceedings before the Mental Health Tribunal for Scotland

We were pleased to see information on rights displayed throughout the William Fraser Centre, including easy read information on rights and a letter that had been

sent to the individual by the RMO, detailing their legal status, their rights in relation to this, and contact numbers for advocacy.

The William Fraser Centre had a seclusion room and a seclusion policy. We were pleased to hear that the seclusion room had not been used in two years. We heard that there were times when seclusion was still used to manage stress and distress however, use of seclusion had significantly reduced, with the use of more therapeutic interventions to manage periods of stress and distress.

We were told that when seclusion was used, it documented clearly on the hospital electronic prescribing and medicines administration (HEPMA) system and included as part of the individual's treatment plans. We were advised that there were plans in place to re-develop the seclusion room as a sensory room for individuals in the learning disability service.

We were pleased to hear that the level of restraint in the William Fraser Centre had continued to reduce. The service had purchased a safety pod to use if restraint was required. We heard that the safety pod promoted a more dignified, safe and compassionate approach to restraint for individuals who required it.

Sections 281 to 286 of the Mental Health Act provide a framework in which restrictions can be placed on people who are detained in hospital. Where a person is a specified person in relation to this and where restrictions are introduced, it is important that the principle of least restriction is applied. Where specified person restrictions were in place under the Mental Health Act, we found inconsistencies in the completion of documentation. In most of the documentation we reviewed, we found the relevant documentation that included a comprehensive reasoned opinion and regular reviews of the restrictions in place. In one record, we found specified person documentation that had expired, and incorrect paperwork completed to extend the specified measures in place. We raised this with the consultant psychiatrist, CNM and CN on the day of the visit and reiterated the importance of a system for auditing all Mental Health Act documentation.

When we are reviewing care records, we looked for copies of advance statements. The term 'advance statement' refers to written statements made under sections 275 and 276 of the Mental Health Act and is written when a person has capacity to make decisions on the treatments they want or do not want. Health boards have a responsibility for promoting advance statements. We were pleased to see and hear about a project the service had initiated to promote advance statements. We saw a large information board in one of the wards that displayed easy read information on advance statements. On review of the care records, we saw that some individuals had completed an advance statement and that there had been discussion with other individuals regarding advance statements.

Following the visit, the Commission contacted the advocacy services who attended the William Fraser Centre. We were told that individuals engaged well in advocacy support and that staff supported and promoted this involvement. We heard from advocacy services that staff in William Fraser Centre were "professional and friendly" and that communication was good. We heard that advocacy services were regularly invited to support individuals in a variety of meetings, for example, individuals who were involved in discharge planning and CPA meetings.

We heard from some individuals that they would like the community meetings in William Fraser Centre to re-commence. Some individuals felt that there was no forum to raise and discuss ward-based issues and that a community meeting would help facilitate communication, address ward-related concerns and support care and treatment.

The Commission has developed *Rights in Mind.*[1] This pathway is designed to help staff in mental health services ensure that people have their human rights respected at key points in their treatment.

Activity and occupation

We heard and saw evidence of a broad range of activities that were available for individuals in and out with the ward. The William Fraser Centre had a recreational assistant who provided activity four days a week. Activity was also provided by nursing staff and OT assistants.

Activities available in the William Fraser Centre included art psychotherapy, music therapy, cooking groups, outings to the local community parks and cafes, visits to the HIVE day service, board games, darts and shopping trips.

There was a weekly timetable of activities provided in the wards. We were told that there was a daily ward morning meeting in which each ward in the unit was discussed. Decisions were made by the MDT on which individuals who would benefit from engaging in the activity available that day and this activity would be offered to the individual.

We were pleased to find each individual had an activity treatment plan and timetable that recorded a programme of activities related to the individual's interests, assessed needs, goals and outcomes. The activity treatment plans were person-centred and focused on what activities supported the admission outcomes and discharge planning.

We were pleased to find many activity timetables included vocational and educational activity and occupation. Some individuals raised that they would like to be involved in more community and volunteering activities and felt there were

[1] *Rights in Mind*: https://www.mwcscot.org.uk/law-and-rights/rights-mind

unnecessary restrictions in place, preventing them from engaging in some activities. We reviewed the care records and risk assessments for these individuals and were satisfied that the current activity care plans were proportionate to the assessed risks and risk management plan.

We heard and saw that some individuals spent a lot of time engaging in community activities and were supported by third sector agencies. This additional support had been commissioned by social work to facilitate discharge planning. Individuals and staff that we spoke with were positive about this support.

Some individuals and advocacy raised that there were occasions when a planned trip was cancelled due to staff shortages. We discussed this matter with the senior management team who confirmed that on occasion, it was necessary to cancel outings in order to respond to clinical acuity; however, staff recognised the importance of activity outings and made all efforts not to cancel trips.

The William Fraser Centre had support from the Cyrennian's volunteer group to help develop their garden. The Cyrennians attended the centre regularly and offered group and individual gardening sessions. We also heard and saw that volunteers attended the ward with therapets, which the individuals enjoyed.

The physical environment

William Fraser Centre was divided into three areas, Starthaird, Culzean and Rannochmor. On the day of the visit, Culzean had four males, Rannochmor three females and Strathaird three females and one male (who had his own private pod area).

All individuals had their own bedroom which was personalised. Most individuals used shared bathroom facilities. Feedback from individuals was that they would prefer en-suite bathroom facilities to promote their privacy and dignity.

Strathaird and Rannochmor had developed a 'pod' in each unit. The pod included a living space, bedroom and ensuite bathroom. We viewed one of the pods on the day of the visit and saw that it was much more spacious than the bedrooms we had viewed and had better facilities that promoted privacy and offered support for individuals as they prepared for independent living; for example, the pods had a living area and bedroom with en-suite facilities.

Each unit had a communal area which had a TV, books, board games, soft furnishings and decoration, such as wall art to make it more homely. We noted the high standard of cleanliness in each ward.

We had made a recommendation in the previous report that managers must prioritise addressing the outstanding environmental issues in relation to repairs, updating fixtures, fittings, decoration, and maintenance issues to make the

environment more homely and therapeutic. While some improvements had been made to the décor, with new flooring fitted throughout the unit, further repair, maintenance work and décor improvement work was required.

Recommendation 4:
Managers must prioritise addressing the outstanding environmental issues in relation to repairs, updating fixtures, fittings, decoration, and maintenance issues to make the environment more homely and therapeutic.

We were concerned to hear of a recent infestation of ants in one of the bedrooms which caused distress for the individual and their family. While we heard that the individual had been moved, we were concerned that the move was unable to happen with immediate effect due to a delay in the estates department being able to respond. We raised this with the senior management team who advised that it was usual for delays in estates responding due to the demands on the estates service.

Although we were pleased by the proactive efforts of the staff team to create a more homely environment for the individuals in the William Fraser Centre, we were disappointed at the lack of improvements made to the building. We were told during the last visit that the ward management team had met with estates and made suggested changes to improve the ward environment, including ensuite facilities for all individuals and renovation of the kitchen to allow individuals access to kitchen facilities on the ward. However, no progress had been made with these plans and there were no assurances given that these renovations would progress.

We would prefer that plans for the new build as part of the Royal Edinburgh Hospital redevelopment project were progressed to provide an environment for the individuals that would promote their safety, privacy and dignity. We were concerned that the individuals' right to privacy and dignity, which is protected by Article 8 of the European Convention on Human Rights, were being compromised due to the current environmental factors.

On the day of the visit, we saw an individual smoking in the shared garden. We asked the senior management team what was being implemented to address smoking in the ward and to create a smoke free environment, in line with current legislation. We were told that individuals were offered smoking cessation and information on the smoking ban. We discussed with the senior management team the importance of staff being supported by senior NHS Lothian managers to enable implementation of the current legislation which prohibits smoking in hospitals.

Recommendation 5:
Managers must ensure compliance with the Smoking, Health and Social Care (Scotland) Act 2005 (part 1) to promote the provision of a safe, pleasant, and

therapeutic environment for all and ensure that staff are given support to manage this.

Any other comments

We heard that ongoing training on positive behaviour support (PBS) had been offered to staff and provided by psychology; we were pleased to hear about an interactive workbook which had been developed for staff to complete alongside study groups to support them to complete the PBS training and promote their skills and knowledge in this area, which was essential for working with individuals in the William Fraser Centre.

We heard that staff felt supported by the senior management team and that the CNM had arranged 'drop-in' sessions for staff on a quarterly basis for them to attend and raise any issues they wanted to discuss.

Good practice

We noted there had been significant improvements made to discharge planning in the unit. This has been supported by the introduction of the discharge co-ordinator role in 2022. We were pleased to hear of the four individuals that had been successfully discharged since our last visit, many of whom had been in hospital for many years.

We were able to see proactive discharge planning for many of the individuals in the unit. We saw evidence of regular communication with social work and a MDT approach to discharge planning that was benefitting the individuals.

Summary of recommendations

Recommendation 1:
Managers should put a system in place to ensure awareness of when a welfare proxy is in place for an individual, and a copy of the document stating the powers of the proxy should be held within the case records.

Recommendation 2:
Managers and the responsible medical officers must ensure that all consent and authority to treat certificates are valid, that all psychotropic medication is legally authorised and that an audit system is put in place to monitor this.

Recommendation 3:
Where a person lacks capacity in relation to decisions about medical treatment, S47 certificates, and where necessary, treatment plans must be completed in accordance with the AWI Act Code of Practice (3rd ed.) and cover all relevant medical treatment the individual is receiving.

Recommendation 4:
Managers must prioritise addressing the outstanding environmental issues in relation to repairs, updating fixtures, fittings, decoration, and maintenance issues to make the environment more homely and therapeutic.

Recommendation 5:
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Service response to recommendations

The Commission requires a response to these recommendations within three months of the publication date of this report. We would also like further information about how the service has shared the visit report with the individuals in the service, and the relatives/carers that are involved. This has been added to the action plan.

A copy of this report will be sent for information to Healthcare Improvement Scotland.

Claire Lamza
Executive director (nursing)

About the Mental Welfare Commission and our local visits

The Commission's key role is to protect and promote the human rights of people with mental illness, learning disabilities, dementia and related conditions.

The Commission visits people in a variety of settings.

The Commission is part of the UK National Preventive Mechanism, which ensures the UK fulfils its obligations under UN treaties to monitor places where people are detained, prevent ill-treatment, and ensure detention is consistent with international standards.

When we visit:

- We find out whether an individual's care, treatment, and support are in line with the law and good practice.
- We challenge service providers to deliver best practice in mental health, dementia, and learning disability care.
- We follow up on individual cases where we have concerns, and we may investigate further.
- We provide information, advice, and guidance to people we meet with.

Where we visit a group of people in a hospital, care home, or prison service; we call this a local visit. The visit can be announced or unannounced.

In addition to meeting with people who use the service we speak to staff and visitors.

Before we visit, we look at information that is publicly available about the service from a variety of sources including Care Inspectorate reports, Healthcare Improvement Scotland inspection reports, and Her Majesty's Inspectorate of Prisons inspection reports.

We also look at information we have received from other sources, including telephone calls to the Commission, reports of incidents to the Commission, information from callers to our telephone advice line, and other sources.

Our local visits are not inspections: our report details our findings from the day we visited. Although there are often particular things we want to talk about and look at when we visit, our main source of information on the visit day is from the people who use the service, their carers, staff, our review of the care records and our impressions about the physical environment.

When we make recommendations, we expect a response to them within three months (unless we feel the recommendations require an earlier response).

We may choose to return to the service on an announced or unannounced basis. How often we do this will depend on our findings, the response to any recommendations from the visit and other information we receive after the visit.

Further information and frequently asked questions about our local visits can be found on our website.

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